VOL. 6, No. 11 NOVEMBER 1952

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

CONTENTS

	Page
Inter-regional Rabies Conference	319
International non-proprietary names for drugs	322
Regional Committee for South-East Asia: fifth session	326
Reports of Expert Groups	
Rehabilitation of the physically handicapped child	329
Review of WHO Publications	
Vital statistics for 1951	331
Reports from WHO Fellows	
Blood transfusion in the USA	334
Notes and News	
Dr. V. A. Sutter appointed Assistant Director-General	336
Biostatistical centre to be established	336
Influenza in 1951–2	337
International Sanitary Regulations enter into force	337
New projects in Eastern Mediterranean Region	337
Endemic yellow fever areas	338
Adoption of the International Pharmacopoeia as national pharmacopoeia	339
Lectures on public health published	340

SCHEDULE OF MEETINGS

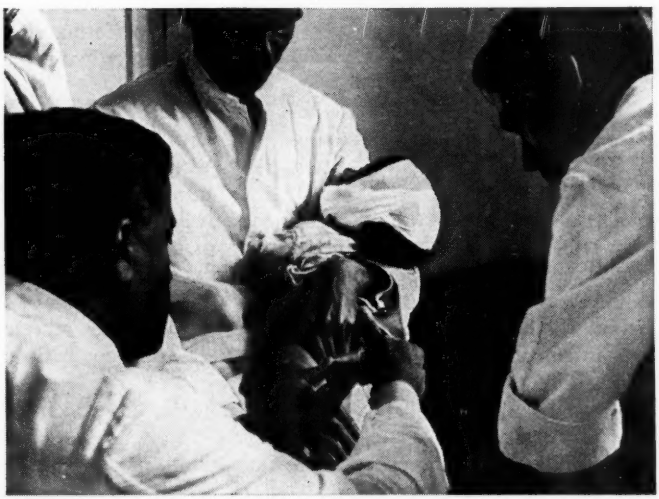
27 October-1 November	**Expert Committee on the International Pharmacopoeia, eleventh session, Geneva**
3-4 November	**Expert Committee on the International Pharmacopoeia, Subcommittee on Non-Proprietary Names, fifth session, Geneva**
10-18 November	**Expert Committee on Leprosy, first session, Rio de Janeiro**
24-29 November	**Expert Committee on Public-Health Administration, second session, Geneva**
24-29 November	**WHO/FAO Seminar on Zoonoses, Vienna**
28 November-4 December	**FAO/WHO Joint Committee on Nutrition (in co-operation with CCTA Nutrition Conference), Fajara, Gambia**
5-10 December	**Expert Committee on Plague, second session, Bombay**
15-20 December	**Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel, second session, Nancy**

INTER-REGIONAL RABIES CONFERENCE

Rabies is a disease in which specialists are few and the demands for international assistance comparatively numerous. To try to meet the demands for aid and to spread the knowledge of recent advances, made largely by the few specialists, WHO sponsored an inter-regional conference on rabies, held at the Pasteur Institute of Southern India, Coonoor, during the last two weeks of July. This conference was unique in that it gave intensive and individual training in complicated laboratory procedures to a large international group. A consultant staff of eight members—from France, India, Israel, and the USA—gave lectures, led discussions, and supervised the laboratory work of 47 participants—including 38 WHO fellowship-holders—from 21 countries, primarily in the Eastern Mediterranean, South-East Asia, and Western Pacific Regions. The Food and Agriculture Organization (FAO) was also represented.

The type of concentrated training which the conference gave may serve as a model for subsequent technical gatherings of this kind. Morning sessions were devoted to lectures and general discussions, and afternoon sessions, to laboratory exercises. The participants worked intensively for about six hours per day and gained experience within twelve days which would have taken months of travel and study to acquire.

FIG. I. INTER-REGIONAL RABIES CONFERENCE - I



During the conference a child who had been bitten by a stray dog was brought to the Institute where, in addition to the usual treatment and vaccination, she was given an injection of a new antirabies serum which had been brought to the meeting by one of the discussion leaders

FIG. 2. INTER-REGIONAL RABIES CONFERENCE - II

The dog which had bitten the child was killed and its body brought to the Institute. Here, Dr. H. Johnson, with the assistance of another of the discussion leaders, is removing the brain so that tests for rabies infection may be made

Among the aspects of rabies studied were : epidemiology ; clinical manifestations ; serum-neutralization test and mouse-inoculation techniques ; pathology ; post-exposure treatment in man and animals ; production of human and veterinary vaccines and sera; potency testing of vaccines; organization of field control-programmes ; laboratory diagnosis of rabies ; care and breeding of laboratory animals ; and research problems. Visual teaching aids such as films, film-strips, and slides were utilized. Laboratory demonstrations by the discussion leaders were followed by actual performance of the procedures by the participants.

One of the objects of the conference was to teach standardized procedures in rabies tests so that the results obtained in laboratories in various parts of the world may be compared. Lack of comparability has, up to now, made impossible any really scientific analysis of much of the work done in rabies. It is felt that the new and standardized techniques which were taught at the conference will be introduced into the majority of countries represented by the participants and will thereby greatly aid future comparisons of results.

Plans were made for collaborative research to be undertaken in the laboratories in which the conference-participants work. Investigations will be concentrated on the effect—in human beings and in animals—of hyper-immune serum combined with various schedules of vaccination procedures; on the efficacy of different forms of local treatment of wounds in preventing rabies; and on modified strains of rabies virus used for vaccines in dogs.

FIG. 3. INTER-REGIONAL RABIES CONFERENCE - III

Participants in the conference actually performing laboratory tests at their work-benches, under the close supervision of the discussion leaders

FIG. 4. INTER-REGIONAL RABIES CONFERENCE - IV

Dr. H. Koprowski (lower right) explains a fine point of laboratory technique to conference-participants

Participants in the conference requested that follow-up assistance be given to them by WHO, particularly with regard to technical difficulties which they may encounter when they return to their own laboratories. They were assured that the Organization will continue to give them technical aid and that every effort will be made to keep them abreast of new developments in rabies control and research.

The discussion leaders at the conference were : Dr. M. L. Ahuja, Director, Central Research Institute, Kasauli, India ; Dr. H. N. Johnson, Virus Resarch Centre, Indian Council of Medical Research, Rockefeller Foundation, Poona, India; Dr. M. M. Kaplan, Chief Veterinary Officer, World Health Organization, Geneva, Switzerland ; Dr. A. Komarov, Director, State Veterinary Laboratory, Virus Section, Haifa, Israel; Dr. H. Koprowski, Assistant Director, Viral and Rickettsial Research Division, Lederle Laboratories, Pearl River, New York, USA; Dr. P. Lépine, Director, Virus Section, Institut Pasteur, Paris, France; Dr. E. S. Tierkel, Veterinary Public Health Division, US Public Health Services, Atlanta, Ga., USA ; and Dr. N. Veeraraghavan, Director, Pasteur Institute, Coonoor, India. Countries represented by the participants included Afghanistan, Australia, Austria, Burma, Ceylon, China, Cyprus, Egypt, India, Indonesia, Iran, Iraq, Israel, Japan, Lebanon, Malaya, the Philippines, Spain, Syria, Thailand, and Turkey.

INTERNATIONAL NON-PROPRIETARY NAMES FOR DRUGS [1]

Chemists throughout the world have, for some time, had a common nomenclature. Even in organic chemistry, despite the considerable difficulties involved, successful efforts are being made to establish a system of nomenclature for the many compounds which are daily being developed. The adoption of an international nomenclature for drugs, however, raises more complicated problems; certain drugs which have been in use for a long time are known in various countries and diverse languages by different names, chosen long before the introduction of a rational system of nomenclature.

At first sight it might seem that, for the numerous drugs which are chemical compounds, the chemical names could be used; but the latter are often so complicated that manufacturers and sales agents spontaneously adopt simpler and shorter names. Obviously " riboflavine " sounds

[1] Summary of a lec ure by P. Blanc, Secretary of the Expert Committee on the International Pharmacopoeia, delivered before the 14th General Assembly of the International Pharmaceutical Federation and published in the *Bull. Fed. int. pharm.* 1950/51, **24**, 138

better and is more easily remembered than 6:7-dimethyl-9-(D-l'-ribityl) *iso*-alloxazine. But, unfortunately, the same substance is known elsewhere by the name of " lactoflavine " or " vitamin B_2 ". Another example may be cited, namely that of the methadone hydrochloride of the *Pharmacopoea Internationalis* (6-dimethylamino-4,4-diphenyl-3-heptanone), which is known in different countries under the following names : amidone, miadone, diadone, diaminon, mephenon, symoron, etc.

Sick persons who are travelling should be able to find the drugs they need in every country, and pharmacists everywhere should interpret in the same way a prescription drawn up in another country. In short, every important drug should have an international non-proprietary name.

The first commission for international pharmaceutical nomenclature was established in 1915 under the auspices of the International Pharmaceutical Federation. A second commission was appointed in 1922 ; and, as early as 1924, a first list of names was submitted to national pharmacopoeia commissions. Some of them adopted this list, arranging to have placed after each name initials identifying it as belonging to the international nomenclature.

The Brussels Agreement of 1929 suggested to the pharmacopoeia authorities of the signatory countries international names for a series of so-called potent drugs, for which specific standards were indicated. Furthermore, one of the articles in the Agreement assigned to the future permanent international pharmacopoeia secretariat (which was to be set up under the auspices of the League of Nations) the duty of formulating proposals which might lead to a uniform nomenclature in pharmacopoeias. The said secretariat has since come under the aegis of WHO.

The Expert Committee on the Unification of Pharmacopoeias of the WHO Interim Commission was established in 1947. At its second meeting, in June 1948, this committee expressed the wish to seek the co-operation of the International Union for the Protection of Industrial Property, with the aim of introducing non-proprietary names for drugs.

In October 1948, a member of the expert committee submitted a note requesting WHO to standardize non-proprietary names and to create, introduce, and have adopted international non-proprietary names for new pharmaceutical chemical compounds, whether included or not in the International Pharmacopoeia. He suggested that these names be in Latin and that they, as well as their translations into the various languages, enjoy international protection and not become the property of business concerns or of individuals.

In January 1949, the Expert Committee on Habit-Forming Drugs recommended, in turn, " that a mechanism should be established whereby every habit-forming drug subject to international control can be given a single name to be used for all international purposes ".[2]

[2] *Off. Rec. World Hlth Org.* **19**, 32

The Expert Committee on the Unification of Pharmacopoeias consequently set to work to fulfil the wishes expressed in various quarters and, in 1950, a series of guiding principles for the selection of international non-proprietary names was submitted to the Third World Health Assembly. These principles are as follows :

(1) Names should, preferably, be free from any anatomical, physiological, pathological, or therapeutic suggestion.

(2) An attempt should first be made to form a name by the combination of syllables from the scientific chemical name, in such a way as to indicate the significant groupings of the compound.

(3) Names should, in general, not exceed four syllables.

(4) Names should be distinctive in sound and spelling, and should not be liable to confusion with names already in use.

(5) Names which are difficult to pronounce or to remember should be avoided.

(6) The addition of a terminal capital letter or number should be avoided.

(7) Names already used in the national pharmacopoeias or officially adopted in any country, or which are included in *New and Nonofficial Remedies*, should receive preferential consideration.

(8) The following terminations should be used :

Latin	*English*	
-inum	-ine	for alkaloids and organic bases
-inum	-in	for glycerides and neutral principles
-osidum	-oside	for glycosides
-olum	-ol	for alcohols and phenols (-OH group)
-alum	-al	for aldehydes
-onum	-one	for ketones and other substances containing the CO group
-enum	-ene	for unsaturated hydrocarbons
-anum	-ane	for saturated hydrocarbons. [3]

The first principle arises both from the desire not to give the patient the idea of some definite disease and from the fact that the therapeutic indications for certain new products have been found in practice to be different from those originally attributed to them.

Principles 2 and 3 are generally accepted and applied. As regards principles 4 and 5, they refer to those cases, no doubt frequent, in which a given non-proprietary name must be amended in a country so as to avoid confusion with common names or with registered trade-marks.

Principle 6 is generally accepted by national pharmacopoeia commissions, and it is considered preferable, for example, to adopt " ascorbic acid " rather than " vitamin C ".

Principle 7 encourages the adoption, by preference, of names already employed in the country where the new product has been discovered and put on the market for the first time. This important principle complies

[3] *World Hlth Org. techn. Rep. Ser.* 1951, **43**, 29

with numerous requests, including that of the World Medical Association. The Expert Committee on the International Pharmacopoeia has also declared that any name suggested by the person making a discovery, if it is not contradictory to these principles, should be given favourable consideration.

Principle 8 (the endings to be used) must be applied on a fairly wide basis so as to cover the majority of cases. It is possible that it may be subsequently amended and extended. International non-proprietary names will always be established in Latin, with French and English translations.

It is recommended, furthermore, that all products which have received an international non-proprietary name and which are sold under a trade mark should also bear the international non-proprietary name on the label.

The above principles were communicated to WHO Member States in April 1950. Thirty-two Member States have declared themselves to be in general agreement with the principles approved by the World Health Assembly. Exchanges of views have taken place with several national pharmacopoeia commissions and with various interested national or international organizations.

A Subcommittee on Non-Proprietary Names has been attached to the Expert Committee on the International Pharmacopoeia. Since its creation, this subcommittee has selected or approved several hundred international non-proprietary names.[4] The names are chosen as follows : National pharmacopoeia authorities and other competent bodies are asked to invite manufacturers and research laboratories to inform them of new pharmaceutical products which might later be incorporated into the International Pharmacopoeia and for which it would be necessary to adopt international non-proprietary names. They are also requested to inform WHO of these products. When necessary, to save time, manufacturers, research laboratories, and universities may report these products directly to WHO. Between the sessions of the Expert Committee on the International Pharmacopoeia, suggestions presented by a member or by one of the above-mentioned authorities are communicated in writing to the chairman of the subcommittee, who submits a proposed name to the other members of the subcommittee. If they do not accept this proposal, they inform the chairman to this effect. The chairman is empowered to select the final name after one or two exchanges of views. Whenever possible, the subcommittee collaborates closely with the pharmacopoeia authorities.

All this represents a very difficult task. It is necessary to search out the names which are registered or in use in the various countries so that the proposed names will not duplicate those of already existing trade-marks. Furthermore, measures must be taken with a view to " preventing the use

[4] Lists of non-proprietary names for the drugs to be included in Volume II of the *Pharmacopoea Internationalis* and for certain other drugs have been published in *World Hlth Org. techn. Rep. Ser.* 1951, 35, 28 ; 43, 30

SCHEDULE OF MEETINGS

27 October-1 November	**Expert Committee on the International Pharmacopoeia, eleventh session, Geneva**
3-4 November	**Expert Committee on the International Pharmacopoeia, Subcommittee on Non-Proprietary Names, fifth session, Geneva**
10-18 November	**Expert Committee on Leprosy, first session, Rio de Janeiro**
24-29 November	**Expert Committee on Public-Health Administration, second session, Geneva**
24-29 November	**WHO/FAO Seminar on Zoonoses, Vienna**
28 November-4 December	**FAO/WHO Joint Committee on Nutrition (in co-operation with CCTA Nutrition Conference), Fajara, Gambia**
5-10 December	**Expert Committee on Plague, second session, Bombay**
15-20 December	**Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel, second session, Nancy**

INTER-REGIONAL RABIES CONFERENCE

Rabies is a disease in which specialists are few and the demands for international assistance comparatively numerous. To try to meet the demands for aid and to spread the knowledge of recent advances, made largely by the few specialists, WHO sponsored an inter-regional conference on rabies, held at the Pasteur Institute of Southern India, Coonoor, during the last two weeks of July. This conference was unique in that it gave intensive and individual training in complicated laboratory procedures to a large international group. A consultant staff of eight members—from France, India, Israel, and the USA—gave lectures, led discussions, and supervised the laboratory work of 47 participants—including 38 WHO fellowship-holders—from 21 countries, primarily in the Eastern Mediterranean, South-East Asia, and Western Pacific Regions. The Food and Agriculture Organization (FAO) was also represented.

The type of concentrated training which the conference gave may serve as a model for subsequent technical gatherings of this kind. Morning sessions were devoted to lectures and general discussions, and afternoon sessions, to laboratory exercises. The participants worked intensively for about six hours per day and gained experience within twelve days which would have taken months of travel and study to acquire.

FIG. I. INTER-REGIONAL RABIES CONFERENCE - I

During the conference a child who had been bitten by a stray dog was brought to the Institute where, in addition to the usual treatment and vaccination, she was given an injection of a new antirabies serum which had been brought to the meeting by one of the discussion leaders

FIG. 2. INTER-REGIONAL RABIES CONFERENCE - II

The dog which had bitten the child was killed and its body brought to the Institute. Here, Dr. H. Johnson, with the assistance of another of the discussion leaders, is removing the brain so that tests for rabies infection may be made

Among the aspects of rabies studied were : epidemiology ; clinical manifestations ; serum-neutralization test and mouse-inoculation techniques ; pathology ; post-exposure treatment in man and animals ; production of human and veterinary vaccines and sera ; potency testing of vaccines ; organization of field control-programmes ; laboratory diagnosis of rabies ; care and breeding of laboratory animals ; and research problems. Visual teaching aids such as films, film-strips, and slides were utilized. Laboratory demonstrations by the discussion leaders were followed by actual performance of the procedures by the participants.

One of the objects of the conference was to teach standardized procedures in rabies tests so that the results obtained in laboratories in various parts of the world may be compared. Lack of comparability has, up to now, made impossible any really scientific analysis of much of the work done in rabies. It is felt that the new and standardized techniques which were taught at the conference will be introduced into the majority of countries represented by the participants and will thereby greatly aid future comparisons of results.

Plans were made for collaborative research to be undertaken in the laboratories in which the conference-participants work. Investigations will be concentrated on the effect—in human beings and in animals—of hyper-immune serum combined with various schedules of vaccination procedures ; on the efficacy of different forms of local treatment of wounds in preventing rabies ; and on modified strains of rabies virus used for vaccines in dogs.

FIG. 3. INTER-REGIONAL RABIES CONFERENCE - III

Participants in the conference actually performing laboratory tests at their work-benches, under the close supervision of the discussion leaders

FIG. 4. INTER-REGIONAL RABIES CONFERENCE - IV

Dr. H. Koprowski (lower right) explains a fine point of laboratory technique to conference-participants

Participants in the conference requested that follow-up assistance be given to them by WHO, particularly with regard to technical difficulties which they may encounter when they return to their own laboratories. They were assured that the Organization will continue to give them technical aid and that every effort will be made to keep them abreast of new developments in rabies control and research.

The discussion leaders at the conference were : Dr. M. L. Ahuja, Director, Central Research Institute, Kasauli, India ; Dr. H. N. Johnson, Virus Resarch Centre, Indian Council of Medical Research, Rockefeller Foundation, Poona, India; Dr. M. M. Kaplan, Chief Veterinary Officer, World Health Organization, Geneva, Switzerland ; Dr. A. Komarov, Director, State Veterinary Laboratory, Virus Section, Haifa, Israel; Dr. H. Koprowski, Assistant Director, Viral and Rickettsial Research Division, Lederle Laboratories, Pearl River, New York, USA; Dr. P. Lépine, Director, Virus Section, Institut Pasteur, Paris, France; Dr. E. S. Tierkel, Veterinary Public Health Division, US Public Health Services, Atlanta, Ga., USA ; and Dr. N. Veeraraghavan, Director, Pasteur Institute, Coonoor, India. Countries represented by the participants included Afghanistan, Australia, Austria, Burma, Ceylon, China, Cyprus, Egypt, India, Indonesia, Iran, Iraq, Israel, Japan, Lebanon, Malaya, the Philippines, Spain, Syria, Thailand, and Turkey.

INTERNATIONAL NON-PROPRIETARY NAMES FOR DRUGS [1]

Chemists throughout the world have, for some time, had a common nomenclature. Even in organic chemistry, despite the considerable difficulties involved, successful efforts are being made to establish a system of nomenclature for the many compounds which are daily being developed. The adoption of an international nomenclature for drugs, however, raises more complicated problems; certain drugs which have been in use for a long time are known in various countries and diverse languages by different names, chosen long before the introduction of a rational system of nomenclature.

At first sight it might seem that, for the numerous drugs which are chemical compounds, the chemical names could be used; but the latter are often so complicated that manufacturers and sales agents spontaneously adopt simpler and shorter names. Obviously " riboflavine " sounds

[1] Summary of a lec ure by P. Blanc, Secretary of the Expert Committee on the International Pharmacopoeia, delivered before the 14th General Assembly of the International Pharmaceutical Federation and published in the *Bull. Fed. int. pharm.* 1950/51, **24**, 138

better and is more easily remembered than 6:7-dimethyl-9-(D-l'-ribityl) *iso*-alloxazine. But, unfortunately, the same substance is known elsewhere by the name of " lactoflavine " or " vitamin B_2 ". Another example may be cited, namely that of the methadone hydrochloride of the *Pharmacopoea Internationalis* (6-dimethylamino-4,4-diphenyl-3-heptanone), which is known in different countries under the following names : amidone, miadone, diadone, diaminon, mephenon, symoron, etc.

Sick persons who are travelling should be able to find the drugs they need in every country, and pharmacists everywhere should interpret in the same way a prescription drawn up in another country. In short, every important drug should have an international non-proprietary name.

The first commission for international pharmaceutical nomenclature was established in 1915 under the auspices of the International Pharmaceutical Federation. A second commission was appointed in 1922 ; and, as early as 1924, a first list of names was submitted to national pharmacopoeia commissions. Some of them adopted this list, arranging to have placed after each name initials identifying it as belonging to the international nomenclature.

The Brussels Agreement of 1929 suggested to the pharmacopoeia authorities of the signatory countries international names for a series of so-called potent drugs, for which specific standards were indicated. Furthermore, one of the articles in the Agreement assigned to the future permanent international pharmacopoeia secretariat (which was to be set up under the auspices of the League of Nations) the duty of formulating proposals which might lead to a uniform nomenclature in pharmacopoeias. The said secretariat has since come under the aegis of WHO.

The Expert Committee on the Unification of Pharmacopoeias of the WHO Interim Commission was established in 1947. At its second meeting, in June 1948, this committee expressed the wish to seek the co-operation of the International Union for the Protection of Industrial Property, with the aim of introducing non-proprietary names for drugs.

In October 1948, a member of the expert committee submitted a note requesting WHO to standardize non-proprietary names and to create, introduce, and have adopted international non-proprietary names for new pharmaceutical chemical compounds, whether included or not in the International Pharmacopoeia. He suggested that these names be in Latin and that they, as well as their translations into the various languages, enjoy international protection and not become the property of business concerns or of individuals.

In January 1949, the Expert Committee on Habit-Forming Drugs recommended, in turn, " that a mechanism should be established whereby every habit-forming drug subject to international control can be given a single name to be used for all international purposes ".[2]

[2] *Off. Rec. World Hlth Org.* **19**, 32

The Expert Committee on the Unification of Pharmacopoeias consequently set to work to fulfil the wishes expressed in various quarters and, in 1950, a series of guiding principles for the selection of international non-proprietary names was submitted to the Third World Health Assembly. These principles are as follows :

(1) Names should, preferably, be free from any anatomical, physiological, pathological, or therapeutic suggestion.

(2) An attempt should first be made to form a name by the combination of syllables from the scientific chemical name, in such a way as to indicate the significant groupings of the compound.

(3) Names should, in general, not exceed four syllables.

(4) Names should be distinctive in sound and spelling, and should not be liable to confusion with names already in use.

(5) Names which are difficult to pronounce or to remember should be avoided.

(6) The addition of a terminal capital letter or number should be avoided.

(7) Names already used in the national pharmacopoeias or officially adopted in any country, or which are included in *New and Nonofficial Remedies*, should receive preferential consideration.

(8) The following terminations should be used :

Latin	*English*	
-inum	-ine	for alkaloids and organic bases
-inum	-in	for glycerides and neutral principles
-osidum	-oside	for glycosides
-olum	-ol	for alcohols and phenols (-OH group)
-alum	-al	for aldehydes
-onum	-one	for ketones and other substances containing the CO group
-enum	-ene	for unsaturated hydrocarbons
-anum	-ane	for saturated hydrocarbons. [3]

The first principle arises both from the desire not to give the patient the idea of some definite disease and from the fact that the therapeutic indications for certain new products have been found in practice to be different from those originally attributed to them.

Principles 2 and 3 are generally accepted and applied. As regards principles 4 and 5, they refer to those cases, no doubt frequent, in which a given non-proprietary name must be amended in a country so as to avoid confusion with common names or with registered trade-marks.

Principle 6 is generally accepted by national pharmacopoeia commissions, and it is considered preferable, for example, to adopt " ascorbic acid " rather than " vitamin C ".

Principle 7 encourages the adoption, by preference, of names already employed in the country where the new product has been discovered and put on the market for the first time. This important principle complies

[3] *World Hlth Org. techn. Rep. Ser.* 1951, 43, 29

with numerous requests, including that of the World Medical Association. The Expert Committee on the International Pharmacopoeia has also declared that any name suggested by the person making a discovery, if it is not contradictory to these principles, should be given favourable consideration.

Principle 8 (the endings to be used) must be applied on a fairly wide basis so as to cover the majority of cases. It is possible that it may be subsequently amended and extended. International non-proprietary names will always be established in Latin, with French and English translations.

It is recommended, furthermore, that all products which have received an international non-proprietary name and which are sold under a trade mark should also bear the international non-proprietary name on the label.

The above principles were communicated to WHO Member States in April 1950. Thirty-two Member States have declared themselves to be in general agreement with the principles approved by the World Health Assembly. Exchanges of views have taken place with several national pharmacopoeia commissions and with various interested national or international organizations.

A Subcommittee on Non-Proprietary Names has been attached to the Expert Committee on the International Pharmacopoeia. Since its creation, this subcommittee has selected or approved several hundred international non-proprietary names.[4] The names are chosen as follows : National pharmacopoeia authorities and other competent bodies are asked to invite manufacturers and research laboratories to inform them of new pharmaceutical products which might later be incorporated into the International Pharmacopoeia and for which it would be necessary to adopt international non-proprietary names. They are also requested to inform WHO of these products. When necessary, to save time, manufacturers, research laboratories, and universities may report these products directly to WHO. Between the sessions of the Expert Committee on the International Pharmacopoeia, suggestions presented by a member or by one of the above-mentioned authorities are communicated in writing to the chairman of the subcommittee, who submits a proposed name to the other members of the subcommittee. If they do not accept this proposal, they inform the chairman to this effect. The chairman is empowered to select the final name after one or two exchanges of views. Whenever possible, the subcommittee collaborates closely with the pharmacopoeia authorities.

All this represents a very difficult task. It is necessary to search out the names which are registered or in use in the various countries so that the proposed names will not duplicate those of already existing trade-marks. Furthermore, measures must be taken with a view to " preventing the use

[4] Lists of non-proprietary names for the drugs to be included in Volume II of the *Pharmacopoea Internationalis* and for certain other drugs have been published in *World Hlth Org. techn. Rep. Ser.* 1951, 35, 28 ; 43, 30

of names selected for unauthorized purposes "[5] and to prevent individuals or commercial enterprises from taking over these names for their own purposes.

Two methods have been suggested to ensure protection for international non-proprietary names. The International Union for the Protection of Industrial Property might study the possibility of including provisions to this effect in the International Convention for the Protection of Industrial Property. In addition, the Expert Committee on the International Pharmacopoeia and WHO could suggest to the World Health Assembly the adoption of international regulations by virtue of which Member States would pledge themselves to give effective protection to the international non-proprietary names.

The introduction of satisfactory non-proprietary names calls for the co-operation of all organizations and persons concerned; the success of this undertaking depends above all on the voluntary adoption of the international names by the different countries.

[5] See Resolution WHA 3.11 of the Third World Health Assembly, *Off. Rec. World Hlth Org.* **28**, 19.

REGIONAL COMMITTEE FOR SOUTH-EAST ASIA

Fifth Session

The keynote of the fifth session of the WHO Regional Committee for South-East Asia was the urgent need for trained medical and auxiliary personnel to care for the population of about 500 million people. This need was emphasized in speeches by the retiring Chairman, Dr. S. Daengsvang, of Thailand, and by H.E. Dr. J. Leimena, Minister of Health of Indonesia, who addressed the opening meeting of the session, held in Bandung from 4 to 9 September 1952. Dr. M. Soerono, Secretary-General of the Ministry of Health of Indonesia, was elected Chairman of the session, and Dr. W. A. Karunaratne, of Ceylon, Vice-Chairman. Present were delegates from Afghanistan, Burma, Ceylon, France, India, Indonesia, and Thailand.

Annual Report of Regional Activities

As a partial solution to the problem of inadequate numbers of trained medical personnel, the Regional Director, in his annual report to the committee, appealed for concentration on training a "vast army" of auxiliary workers to aid in the development of health programmes and services in rural areas, where the situation is most critical. He pleaded for a

shift in emphasis from curative to preventive measures, from efforts to meet the demands of sick persons to attempts to reduce the sources of sickness. The sickness in the region would be almost halved, he maintained, if only malaria could be controlled and safe drinking water provided.

Considerable progress in malaria control has already been achieved in the region, as was revealed by his report of activities and accomplishments. WHO/UNICEF projects in four areas of India have been followed by government plans for a nationwide antimalaria campaign, aided by the United States Point IV Programme, which should protect 200 million persons over the next five years. Similar demonstrations by WHO have also stimulated government programmes in Afghanistan, Burma, Indonesia, and Thailand. In Ceylon, a national campaign which has been under way, without outside help, for five years is being continued. Plants for the manufacture of DDT for use in malaria control are being constructed in Ceylon and in India, with WHO and UNICEF assistance.

The delegates learned from the report that WHO now has 110 workers engaged in more than 65 projects in South-East Asia. In addition to malaria control, these projects deal with tuberculosis, treponematoses, and other communicable diseases; maternal and child health; nursing; nutrition; and medical education and training of auxiliary personnel. Highlights of the Regional Director's report concerning these activities follow.

Tuberculosis : Five tuberculosis training and demonstration centres have been established in Burma, India (three centres), and Thailand, with aid from WHO and UNICEF. In mass BCG-vaccination surveys and campaigns, 140,000 persons were tested and 42,000 vaccinated in Burma; 8,500,000 tested and 2,500,000 vaccinated in India; and 40,000 tested and 11,000 vaccinated in Thailand.

Treponematoses : In WHO/UNICEF antiyaws projects, 384,000 patients in Indonesia and 186,000 in Thailand have received treatment. Venereal-disease-control training centres have been opened in Afghanistan, Burma, Ceylon, and India. Penicillin, which is essential in the treatment of the treponemal diseases, is to be manufactured at a factory now under construction in India, with WHO and UNICEF assistance.

Maternal and child health : WHO and UNICEF are aiding in the improvement of maternal and child health services in Afghanistan, Burma, Ceylon, India, Indonesia, and Thailand. Stress is being laid on training essential personnel, particularly for work among rural populations, which comprise about 80% of the total population of South-East Asia. An effort is made, wherever possible, to integrate maternal and child health programmes into comprehensive rural health services.

Nursing : Eight projects for training nurses have been developed in connexion with existing nursing shools in the region, and six short-term courses were initiated during the year. More than 40 WHO nurse specialists are now serving in projects in South-East Asia.

Nutrition : A three-month course, sponsored by WHO and FAO, gave training to 24 students from six countries of the region. WHO nutrition experts are aiding in projects in Burma, Ceylon, and Indonesia.

Medical education and training : In addition to training activities carried out in connexion with all field projects and to special courses and seminars in specific subjects, WHO has aided by providing teaching personnel; by sending a visiting team of medical scientists on a teaching mission to Burma, Ceylon, and India; and by administering 90 fellowships, financed by UNICEF, United Nations technical assistance funds, and WHO itself.

Additional projects : Other activities have included assistance in the control of typhus in Afghanistan, plague and cholera in India, leprosy in Burma and Ceylon, and filariasis in South Thailand. Vital and health statistics were the subject of a course given to 30 participants from seven countries. A consultant and two field workers in family planning helped the Government of India initiate pilot studies. Afghanistan was given aid in public-health administration and environmental sanitation.

Committee Decisions

The health programme approved by the Regional Committee for South-East Asia for 1954 calls for an international expenditure of about four million dollars, WHO assistance amounting to over two million and the remainder coming from UNICEF and other sources. This programme consists of projects along the lines of the work already in progress, as reviewed in the Regional Director's report. The delegates adopted a resolution urging modification of WHO's policy so that aid might sometimes be given in the form of provision of equipment and supplies rather than of procurement of foreign personnel.

The committee recommended that, if funds become available, WHO should sponsor the following regional or inter-regional gatherings :

(1) seminar on venereal disease control—Sourabaya, Indonesia, 1954;

(2) regional conference for nursing leaders—India, 1954;

(3) seminar on malaria control—Bangkok, Thailand, 1953 (during the sixth session of the committee);

(4) seminar on paediatrics.

A full day of the session was devoted to technical discussion, under the leadership of Dr. Karunaratne and Dr. Soerono, of two subjects : (*a*) the training of auxiliary health personnel, and (*b*) the problem of health services in rural areas.

The re-appointment, upon expiration of his present contract in December 1953, of Dr. C. Mani as Regional Director was unanimously recommended by the committee; this, however, is subject to approval by the WHO Executive Board. The committee accepted the invitation of the Government of Thailand to hold its 1953 session in Bangkok.

Reports of Expert Groups

REHABILITATION OF THE PHYSICALLY HANDICAPPED CHILD

War of necessity causes rapid growth in the number of physically handicapped persons and increases the community's sense of responsibility towards them. This sense of responsibility—not merely to war victims but to all physically handicapped persons, and especially to children—has been increasingly felt since the second World War, while at the same time advances in medicine and psychology have enlarged the scope of possible rehabilitation measures. In 1950, an ad hoc Technical Working Party on the Rehabilitation of the Physically Handicapped was established by the United Nations to co-ordinate the activities in this field of the United Nations and of its specialized agencies. As the result of a recommendation of the working party at its second session (April 1951), a Joint Expert Committee on the Physically Handicapped Child was established by WHO, with the participation of the United Nations, the International Labour Organisation (ILO), and the United Nations Educational, Scientific and Cultural Organization (UNESCO), and met from 3 to 8 December 1951. The joint committee's report is soon to be published as No. 58 in the *World Health Organization : Technical Report Series.*[1]

Basis of Approach

As a basis of approach to the problem, two principles are affirmed : (1) every child has the right to expect the greatest possible protection against the occurrence of preventable handicap before, during, and after birth; and (2) every disabled child, regardless of the nature of his physical handicap, has the right to develop to the maximum of his abilities in spite of his disablement. It is recognized that physical handicap is not solely a " physical " problem; the disabled child needs not only medical care, but help in adjusting himself emotionally, intellectually, and socially to the consequences of his infirmity.

Prevention of Handicap

Extensive research is required before the incidence of the various conditions causing physical disability can be ascertained. Causative factors may, however, be classified in three main groups : congenital conditions —such as clubfoot, cleft palate, and congenital heart-disease; traumatic conditions—such as amputations, and contractures following burns; and conditions related to various specific diseases, such as poliomyelitis.

---

[1] *World Hlth Org. techn. Rep. Ser.* 1952, **58** (in press)

The best safeguards against the initial occurrence of physical handicap (" primary prevention ") are (*a*) social measures—precautions against industrial accidents, and prevention of the employment of children at an early age or in unsuitable conditions, etc., and (*b*) health measures—the establishment of adequate and generally available public-health services, such as maternal and child health services, improved sanitation services, measures for the control of tuberculosis and venereal disease, and improved nutrition services. Continuous supervision of the health of all children and the development of more accurate methods and better facilities of early diagnosis and treatment are the best way of mitigating the effects of disability (" secondary prevention ").

Physical Rehabilitation and Emotional Adjustment

The physically handicapped child will receive the best medical treatment, and will be able to achieve maximum development within the limit of his infirmities, only if all services concerned—health, social, and educational—work in co-operation. University medical schools, hospitals, public-health units, and the family doctor should collaborate in case-finding, diagnosis, and general treatment. Rehabilitation centres will require the services of a medical director, assisted by a team of experts in different forms of therapy and with protheses and mechanical aids at their disposal. As it is essential that a continuous follow-up system be established for each child throughout the whole period of growth, the rehabilitation programme should form part of the general public-health programme; the public-health nurse and the social worker may then act as the link between the home, the hospital, the school, and other community agencies concerned in the welfare of the child.

Hospital staff, parents, and the general public frequently lack understanding of the attitude best adopted towards the handicapped child, and by word and action inadvertently damage the child's emotional adjustment. Efforts should be made to increase, particularly among hospital personnel, knowledge and understanding of the emotional needs of children; and hospitals and residential institutions should guard against rigidity in treatment.

Education, Vocational Guidance and Training, and Employment

As far as possible, the handicapped child should share in the normal life of his fellows. Irrespective of whether he will be able ultimately to take his place as an employable member of the community, he has a right to receive as thorough a general education as any other child. Whenever possible, he should attend an ordinary school; and even when provision of a special school or home teaching is unavoidable, the importance of normal social contacts must not be overlooked.

Vocational guidance and training should be available to any young person capable of benefiting from them. Whenever possible, the young handicapped person should join in the courses provided at vocational centres and training colleges, and, whether he attends an ordinary or special institution, in all cases the authority concerned should co-operate closely with the young person's parents and family on the one hand, and with the medical and social services on the other.

Young handicapped persons should be eligible for all forms of employment which they are capable of performing satisfactorily and should not be arbitrarily excluded by reason of their infirmity or their ineligibility for insurance schemes. Experience has shown that, from the point of view of production, low rates of absenteeism, and low accident-rates, the handicapped worker compares favourably with other employees, a fact which should be more widely publicized. Where necessary, work in sheltered workshops or in the home should be arranged.

Special Disabilities

While the joint committee considered the problem of physical handicap in general terms only, as applicable to any child who "over an appreciable period ... is prevented by a physical condition from full participation in childhood activities of a social, recreational, educational, or vocational nature", it was recognized that the general principles underlying the conclusions reached are also applicable to children suffering from such special disabilities as mental defect, blindness, and deafness.

Review of WHO Publications

VITAL STATISTICS FOR 1951

In an annual review of world vital statistics, Dr. M. Pascua, Director of the WHO Division of Health Statistics, analyses the data made available to WHO for the whole year 1951 by July 1952.[1] He stresses that these data are, for various reasons, limited in so far as geographical coverage is concerned and not always strictly comparable owing to variations in the quality of statistics from different countries. However, by means of tables and text, his analysis shows general trends in natality and mortality during 1951, with specific sections being devoted to infant and neonatal mortality.

Of particular interest is the following information, drawn from a table giving birth- and death-rates. These rates are based on 1,000 population.

[1] *Epidem. vital Statist. Rep.* 1952, 5, 283

Country	Population (1,000)	Natality-rate	Mortality-rate	Natural increase
Africa				
Egypt *(localities with health bureau)*	8,349	48.1	22.1	26.0
Union of South Africa				
Europeans	2,650	25.5	9.2	16.3
Asiatics	367	36.7	10.7	26.0
Coloured population	1,107	47.8	20.6	27.2
America				
Canada	13,540 [2]	27.1	9.1	18.0
Chile	5,916	32.3	15.7	16.6
Costa Rica	825	47.6	10.7	36.9
Guatemala	2,887	52.1	19.6	32.5
Mexico	26,332	44.6	17.3	27.3
Panama (1950)	748	32.4	9.6	22.8
Puerto Rico	2,254	37.2	9.9	27.3
United States	153,500 [2]	24.5	9.7	14.8
Venezuela	5,030 [2]	44.6	11.3	33.3
Asia				
Ceylon	7,743	40.7	12.9	27.8
Cyprus	492	29.3	8.4	20.9
Israel *(Jewish population)*	1,304	33.2	6.5	26.7
Japan	84,600	25.6	10.0	15.6
Union of India *(registration area)*	270,000 [2]	26.6	15.1	11.5
Europe				
Austria	6,919	14.6	12.7	1.9
Belgium	8,670	16.1	12.6	3.5
Czechoslovakia (1950)	12,340	22.9	11.4	11.5
Denmark	4,303	17.8	8.9	8.9
Finland	4,051	22.8	10.0	12.8
France	42,200	19.5	13.3	6.2
Germany, Federal Republic	48,120	15.7	10.6	5.1
Ireland (Republic of)	2,959	21.2	14.3	6.9
Italy	46,598	18.1	10.3	7.8
Luxembourg	300	14.9	11.7	3.2
Malta *(civilian population)*	315	30.1	11.1	19.0
Netherlands	10,264	22.3	7.6	14.7
Norway	3,295	18.5	8.3	10.2
Portugal	8,606	24.1	12.3	11.8
Spain [3]	28,086	20.0	11.5	8.5
Sweden	7,074	15.6	9.9	5.7
Switzerland	4,750	17.2	10.5	6.7
United Kingdom				
England and Wales	43,800	15.5	12.5	3.0
Scotland	5,114	17.7	12.9	4.8
Northern Ireland	1,373	20.7	12.8	7.9
Yugoslavia	16,340	27.0	14.2	12.8

[2] Provisional figures

[3] Excluding children born alive but dead before registration of their birth, i.e., within 24 hours

Country	Population (1,000)	Natality-rate	Mortality-rate	Natural increase
Oceania				
Australia *(excluding aborigines)*	8,431	22.9	9.7	13.2
New Zealand *(excluding Maoris)*	1,833	24.4	9.6	14.8

In the countries of Europe included in the review there was a marked rise in natality shortly after—or already during—the second World War. Since then the birth-rate has been steadily falling, and this trend continued during 1951. In many countries the decline in birth-rate as compared with previous years was of the order of 1 per 1,000 population. Even so, in most of the countries for which data are available, the birth-rate in 1951 was still equal, or superior, to that immediately before the war. It is interesting to note, however, that natality has decreased in those countries (Italy, Portugal, and Spain) in which it was highest before the war.

In Australia, Canada, New Zealand, the USA, and among the European population of the Union of South Africa, the birth-rate has, during the last few years, remained approximately unchanged, at a general level of 23-27 per 1,000 population, which is higher than before the war. In most of the remaining areas for which data are available, natality is higher and does not, as a rule, show any definite tendency to change. In Japan, however, the birth-rate is declining very rapidly.

Sixteen European countries and areas had a higher death-rate in 1951 than in 1950; only in the Scandinavian countries was there a decrease in death-rate. In the countries on other continents, the death-rates remained practically unchanged, with two exceptions, India and Japan, in which there was a considerable decrease.

With regard to infant mortality, considerable improvement was noted, though not to the same extent as in 1950. Among the countries which recorded lower rates than ever before were Australia (24 infant deaths per 1,000 live births), Denmark (29), Switzerland (30), Finland (35), Scotland (37), Canada (38), Luxembourg (41), France (51), Federal Republic of Germany (53), Japan (57), Austria (62), Spain (62), New Zealand (Maori population) (68), and Portugal (89).

In most of the countries for which data on neonatal mortality are available—some referring still to 1950—slight improvement was observed.

The review also presents, in tabular form, information concerning natality and general, infant, and neonatal mortality in selected cities in different regions of the world.

Reports from WHO Fellows

Many of the letters and reports received from WHO Fellows are of such interest that they deserve to be read by a wider public. They demonstrate more vividly than a series of facts and figures both the character of the fellowship programme and the response of the Fellows themselves. Selections from these reports are therefore published from time to time, but it must be emphasized that the opinions expressed are those of the Fellows.

Blood Transfusion in the USA

Dr. M. Carrière, chief of the laboratory at the Regional Blood Transfusion Centre at Toulouse (France), was the recipient of a WHO fellowship which enabled him to study certain problems in blood transfusion in the USA for four months. There follows a summary of some of his observations.

Dr. Carrière's report deals with the organization of the national blood transfusion service, the operation of a private centre (blood bank), the techniques employed in certain laboratories in the preparation and use of serum tests, and, finally, the preparation and preservation of various blood derivatives. Only the first two of these subjects will be discussed in this summary.

Organization of blood transfusion services in the USA

Three types of organizations are concerned with the collection and the supply of blood to doctors : the Red Cross, private centres, and military centres. The Red Cross plays the most important role. With the approval of the principal medical associations, the Army, the Air Force, and the Navy, the Red Cross was officially authorized in 1947 to resume in time of peace the tasks which it had carried out during the war—that is, the collection, preparation, and distribution of blood and its derivatives throughout the nation. This is known as the National Blood Program, which serves civilians as well as military personnel.

The National Blood Program is under the scientific direction of a committee on blood and its derivatives. It applies the methods recommended by the National Institutes of Health (Bethesda, Md.). The central office is in Washington, D.C., and the country is divided into four zones : west, central, south-east, and north-east, with offices in San Francisco, St. Louis, Atlanta, and Alexandria, respectively. There are already more than 45 regional centres. Mobile Red Cross units, numerous and well-equipped, regularly visit even very isolated localities to collect blood. A special coach on the Western Pacific Railroad serves as a blood-collection centre; even the use of aeroplanes and helicopters is contemplated.

This programme is financed largely through voluntary contributions. All the Red Cross donors are unpaid. The Red Cross undertakes the expenses involved in analysing and preparing the blood, and no profit is expected. Its activity is generally limited to the collection of blood and the preparation of liquid plasma. Dried plasma or fractionation products are prepared by special firms from surplus blood collected or from blood sent back to the Red Cross by hospitals when they have not used it within 21 days.

The Red Cross participates in the Civil Defense Program. In anticipation of bombing, supplies of plasma have been stored at easily accessible points on the outskirts of large

cities—within a radius of 80 to 160 kilometres. Storage of supplies of blood substitutes (subtosan, gelatin, dextran) has also been recommended, although their clinical application is still under study.

The Red Cross has tried to organize blood typing on a community-wide basis. If this were accomplished, large quantities of type-O blood could be made immediately available in case of emergency transfusions while a supply of homologous blood was being awaited. Mass testing has already been undertaken in large cities and their blood type made known to the persons tested. Also as part of the Civil Defense Program, the Red Cross gives training in blood-transfusion techniques to volunteer workers.

There are numerous private blood-collection centres, either completely independent or attached to hospitals. The principle of " blood banking " requires that the blood supplied for transfusions be replaced by an equal quantity of blood given by relatives or friends of the patient, who pays, in addition, $7.50 for the expenses involved in analysis and preparation of the blood. This expense may be avoided if a second donation of blood is made. The system is actually quite flexible and permits various arrangements.

In general, private centres do not collect more blood than they need. Some of them have recourse to professional donors, who are comparatively low paid, and then resell the blood at a profit. Others have contracts with the Red Cross and can count on its aid in case of need.

Finally, there are centres which are purely military, the Army, Air Force, and Navy being authorized to take blood from donors who want particularly to give to those wounded in battle.

The blood bank

The Blood and Plasma Exchange Bank of New York University is one of the largest private blood centres, drawing blood from 350 to 400 donors per day by means of an " assembly line " staff of 140 persons. Blood is bought at $5.00 a pint and resold at $12. The bank works only for New York State and has no contract with the Red Cross. Dr. Carrière describes the operation of this centre.

Blood is drawn from 8:00 A.M. until 10:00 P.M. without interruption. Donors can give blood only at six-week intervals. A system of identification cards and labelling of tubes and bottles aids in avoiding errors and facilitates the steps of the operation and the reading of results of analyses. The donor is first pricked in the finger; a drop of blood serves for the determination of haemoglobin concentration and for the initial typing. After a medical examination, the donor passes into a room where the blood is drawn. He is provided with a cooled bottle containing 120 ml of an anticoagulant solution and with four haemolysis tubes, one containing a mixture of Wintrobe anticoagulant and the other three intended for a serological test (VDRL), the Simonin repetition test, and a cross-matching test. When the blood has been drawn, two of the tubes are sent to two different posts so that tests may be run simultaneously : at one place, a blood-typing test, with the aid of A and B antisera, and Rh determination, with Rh antiserum, are performed (if the Rh is found negative, the blood is sent to an Rh laboratory); at the other, natural agglutinins are determined, by means of a suspension of fresh red-blood corpuscles (A and B).

The laboratories attached to the blood bank are highly specialized. They perform repeated control tests which might seem excessive but which give the doctors using the blood almost absolute security.

Other questions

In the rest of his report, Dr. Carrière summarizes the minimum requirements established by the National Institutes of Health for the titre, avidity, and potency of anti-A,

anti-B, anti-Rh, and other sera. He calls attention to recently discovered antigens and antibodies. Finally, he discusses the preparation and conservation of blood and its derivatives at the laboratories of Professor E. J. Cohn at Harvard Medical School. The development of a new, mobile, self-contained unit of modest size may make possible at regional blood banks the separation of blood elements and the fractionation of plasma proteins, until now very complicated procedures. This apparatus has as new features the use of recipients and connecting tubes with non-wettable walls, reproducing as far as possible the characteristics of blood vessels; vertical centrifugation; the use of heavy metals as precipitating agents of the various constituents of plasma; and the use of ion exchange resins for making the blood non-coagulable or for removing from blood derivatives all traces of metal which may have been introduced in their preparation. The American Red Cross is much interested in the practical application of this apparatus and in the conservation of the blood elements, which are more easily obtained by its use. The latter problem is the subject of intensive research being conducted at the Harvard Medical School laboratories under the direction of Drs. Pennell, Sloviter, and Tullis.

Notes and News

Dr. V. A. Sutter Appointed Assistant Director-General

Dr. V. A. Sutter, a member of the WHO staff since 1950, has been named Assistant Director-General in charge of the Department of Advisory Services, replacing Dr. M. G. Candau, who is now Assistant Director of the Pan American Sanitary Bureau, Regional Office of WHO for the Americas.[1]

Dr. Sutter, a citizen of El Salvador, studied at the National University of San Salvador and at Johns Hopkins University, Baltimore, Md., USA. Before joining WHO he held various posts, among them that of medical officer of the Institute of Inter-American Affairs, in which capacity he was in charge of the co-ordination of medical and public-health activities of the Serviço Especial de Saude Publica of Brazil; director of public-health services in El Salvador, from 1939 to 1944; and chief medical officer of UNRRA in China. At WHO he has occupied the posts of Director of the Division of Communicable Diseases and Director of the Division of Organization of Public-Health Services. In his new position, Dr. Sutter will head four of the Organization's major divisions : Communicable Disease Services, Organization of Public-Health Services, Education and Training Services, and Environmental Sanitation.

Biostatistical Centre To Be Established

In collaboration with the United Nations and WHO, the Government of Chile is establishing in Santiago an Inter-American Center of Biostatistics. International aid, consisting of provision of expert and administrative personnel, equipment and supplies, and fellowships, is to be given for five years, subject to availability of funds. WHO's contributions are being made through the expanded programme of technical assistance for economic development.

The objectives of the centre will be : (1) to organize and develop a training centre for vital and health statistics for Latin America; (2) to improve the statistical services of the

[1] *Chron. World Hlth Org.* 1952, 6, 27

Chilean Government so that they may serve as a model for demonstration and training purposes; (3) to develop statistical and research methods and records which will be applicable in Latin American countries; and (4) to develop and demonstrate a system of co-ordination among the central statistical services, the public-health and social services, the civil registration services, and other relevant agencies.

Influenza in 1951-2

A preliminary report from the World Influenza Centre, London, gives information concerning influenza in 1951–2. It reveals that, although there were scattered outbreaks in a number of widely separated places during the winter of 1951–2, there was no evidence of spread comparable to that of the 1950–1 epidemic.[2] The viruses isolated in the two periods were also different : the majority of the 1950–1 strains were of the A-prime type, whereas all of the 35 strains received at the Centre during the winter of 1951–2 were influenza-B viruses. The latter were all closely related to one another serologically and to the Crawley (England, 1946) virus and were only distantly related to the Lee strain. Sixteen strains were received from Italy, 11 from the USA, 3 from England, 2 from the Netherlands, and 1 each from Australia, Denmark, and India.

Reports from South Africa show some influenza there during the early part of winter (May and June 1952). Six strains have been received from Cape Town and two from Johannesburg, all of the A-prime type, Liverpool subtype.

International Sanitary Regulations Enter into Force

On 1 October 1952, the International Sanitary Regulations entered into force. The Regulations, which were adopted unanimously by the Fourth World Health Assembly in May 1951,[3] represent the standardization and modernization of about 13 international sanitary conventions in which countries of the world participated, though not with any great degree of uniformity, from 1907 to 1944.

Having been adopted by the World Health Assembly, the new Regulations will not have to be ratified by the governing bodies of the Organization's Member States, as was the case with preceding regulations of this kind. Application of the Regulations will be studied annually by a WHO expert committee so that technical advice may be given on their application and new knowledge concerning epidemic and quarantinable diseases incorporated into them at some future date.

The International Sanitary Regulations should greatly simplify international travel and transport. Their aim is to protect travellers and countries against the dangers of epidemic diseases and, at the same time, to prevent unnecessary delays in travel and transport because of excessive or arbitrary sanitation measures.

New Projects in Eastern Mediterranean Region

Nursing school in East Pakistan

WHO and UNICEF are assisting in the establishment of a new school of nursing at the Medical College Hospital, Dacca, East Pakistan. Miss Dorothy Potts, of Canada, has gone to East Pakistan to head an international team which will initiate this project. Before proceeding to Dacca, Miss Potts, in the company of the Regional Nursing Adviser, Miss Inger Goetzsche, will visit WHO/UNICEF maternal and child health projects in Karachi, Lahore, and Peshawar.

---

[2] *Chron. World Hlth Org.* 1951, 5, 51, 330

[3] *Chron. World Hlth Org.* 1951, 5, 179

Venereal-disease-control in Saudi Arabia

Dr. Abdel Aziz El-Ghouroury, of Cairo, Egypt, has been sent by WHO to help the Government of Saudi Arabia in a project to control venereal diseases. Dr. El-Ghouroury, a serologist, will aid in establishing a venereal-disease-control laboratory and training centre in Djedda, in surveying the incidence of venereal diseases in the country, and in organizing mass treatment. Other personnel to be provided by WHO for this project includes a venereologist and a public-health nurse, both of whom are being seconded by the Egyptian Government to the Organization for the duration of the international assistance.

Endemic Yellow Fever Areas

Since 1947 WHO has been responsible for the delineation, for purposes of quarantine control, of the endemic yellow fever areas in Africa and America. The latest delineation

FIG. 5. AFRICAN ENDEMIC YELLOW FEVER AREA

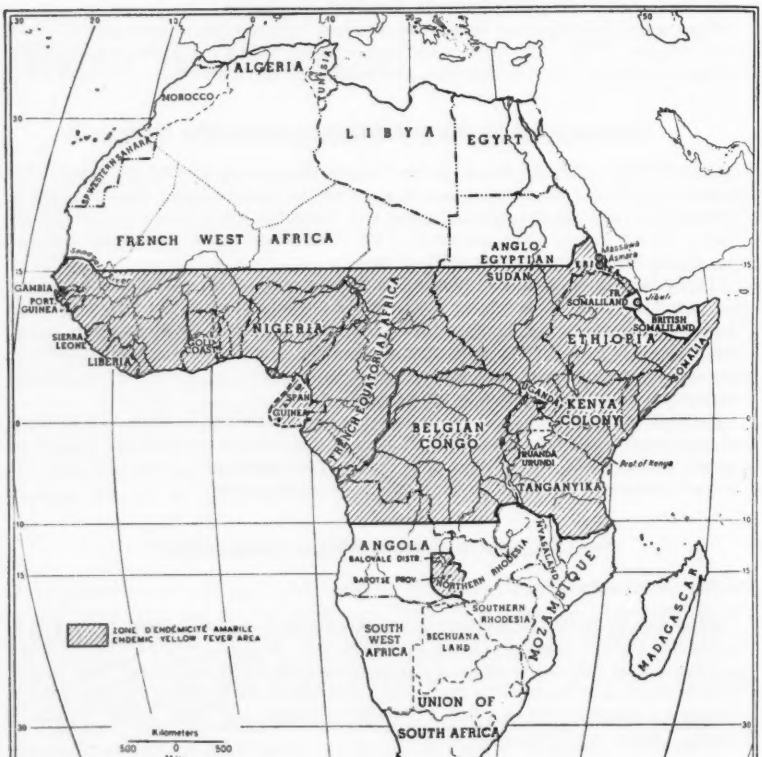


FIG. 6. AMERICAN ENDEMIC YELLOW FEVER AREA

of these areas is shown in fig. 5 and 6 which were published, with accompanying text, in a supplement to a recent *Weekly Epidemiological Record*.[4]

Adoption of the International Pharmacopoeia as National Pharmacopoeia

Israel is the first of the WHO Member States to adopt the *Pharmacopoea Internationalis* as its national pharmacopoeia. An order was recently placed for several hundred copies with a special page in the front bearing an identifying inscription in French or English and in Hebrew.

---

[4] *Wkly epidem. Rec.* 1952, 27, Supplement to No. 300, 25 September

Lectures on Public Health Published

One of the " by-products " of the medical teaching mission sent to Israel in the fall of 1951, under the auspices of WHO and the Unitarian Service Committee,[5] is the publication by the Committee of lectures on public health delivered there by Dr. Karl Evang, Director-General of Public Health of Norway; Dr. John E. Gordon, Professor of Preventive Medicine and Epidemiology, Harvard University, Boston, Mass, USA; and Mr. R. G. Tyler, Professor of Sanitary Engineering, University of Washington, Seattle, Washington, USA.[6] A foreword by Dr. E. Grzegorzewski, Director of the WHO Division of Education and Training Services, explains the purpose of the teaching mission and briefly describes its achievements. This is followed by three lectures by Dr. Evang : " Public health, its scope and its place in the central governmental administration ", " Sickness insurance and its relation to preventive medicine ", and " Trends in the development of hospital functions and administration "; three lectures by Dr. Gordon : " The newer epidemiology ", " The epidemiologic method ", and " American epidemiology in brief perspective "; and two lectures by Mr. Tyler : " The sewage disposal problem in unsewered areas ", and " Fluoridation of public water supplies ".

[5] *Chron. World Hlth Org.* 1952, **6**, 3

[6] Evang, K., Gordon, J. E. & Tyler, R. G. (1952) *Public health lectures*, Unitarian Service Committee, Inc., Boston. Price : $1.00

CORRIGENDUM

1952, Vol. 6, No. 7-8 (August), p. 178

Delete third paragraph, starting " The latter arguments..."

Insert As a result of the discussions, a resolution was adopted (WHA5.43) in which it was requested that the Executive Board, in close collaboration with the Director-General, undertake a thorough study of the rules and criteria for determining the assignment of any territory to a geographical area, making inquiries among the interested Member States and reporting the results to the Sixth World Health Assembly. Pending the results of this study, the Director-General was authorized to take the necessary steps to provide services to territories not yet assigned to regions through Headquarters, under the title " Region undesignated ". However, provisional assignment to the regional organization of their choice was to be made in the case of Member States, Associate Members, and territories or groups of territories for which a request for assignment to a region had been presented. Accordingly, Tunisia and Morocco (that part under French protectorate) were assigned provisionally to the European Region. Spanish Morocco remains attached to the African Region.